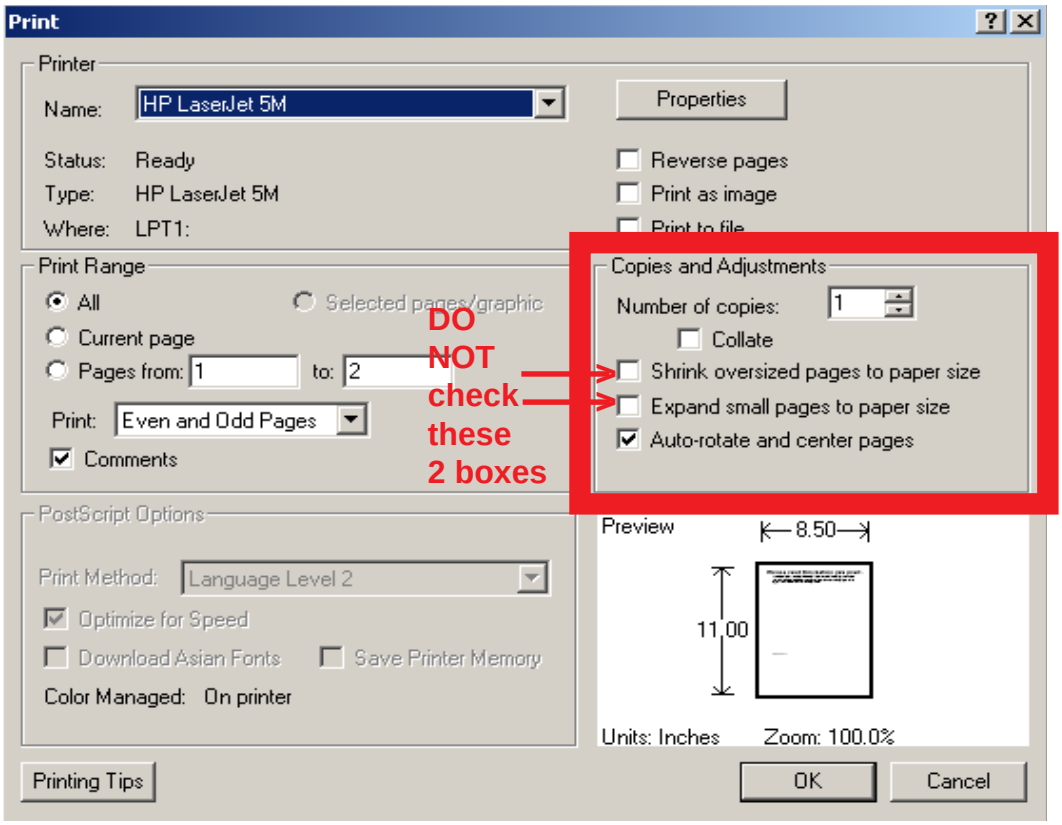
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



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Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Chemical Dependency Professional License Application Packet

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

Chemical Dependency Professional

DEPOSIT SLIP

NAME (Please Print) _____ DATE _____

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$ _____

☐ Check
☐ Money Order

DOH 670-061 (REV 10/2004)

1A 0207060000 00617

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Washington State Department of Health

Application Instructions For Chemical Dependency Professional Certification

Application Fee **$100.00** Initial Certification Fee **$125.00** **ALL FEES ARE NON-REFUNDABLE**	If you are sending **supporting documents** separate from the four-page application form, please mail to the following address:
Send the application and fee to: **Department of Health** **CDP Program** **PO Box 1099** **Olympia, WA 98507-1099**	**Department of Health** **CDP Program** **PO Box 47869** **Olympia, WA 98504-7869**

1. **Demographic Information**

   Please complete the application form. To assure appropriate review, all information should be typed or print clearly. A resume will ***not*** substitute for completion of the application. It is the applicant's responsibility to keep the Department of Health, CDP Program, informed of any address change.

2. **Previous Certification/Licensure/Registration**

   List all states in which you now hold or have held a certification, license, or registration to practice chemical dependency counseling or any other professional certification, license or registration. Also, include those states in which you may have applied for and a certification, license, or registration was not granted. Please include an explanation. Please send the Out of State Verification form to each state in which you held a chemical dependency certification, license, or registration, even if it is now expired.

   (**Note:** regarding the "Method of Licensure", EXAM = examination, END = endorsement, and GP = grandparenting).

3. **Examination Data**

   If you have taken and passed the NAADAC or the ICRC examination, verification must be sent directly to this office by NAADAC or ICRC, or from the state in which you took and passed the examination.

   "What does NAADAC Certification or ICRC International certification do for me?" A person who is certified with NAADAC or internationally certified with ICRC is considered to have met all of the experience requirements, and half of the educational requirement. Certification verifies the forty-five quarter or thirty semester hours of topics listed in WAC 246-811-030(2)(a) through (w). Because certification in one of these organizations verifies your experience, verification forms are not required. However, transcripts need to be sent to the department to verify the additional forty-five quarter or thirty semester credits in courses covering the subject content described in WAC 246-811-030(2). Please request NAADAC or ICRC to forward verification of your certification directly to this office.

4. **Personal Data Questions**

   If any questions on the Personal Data page have a “Yes” response, the supporting documents and explanation required for that answer must be attached. If you were previously registered as a counselor under RCW 18.19 and answered yes to a personal data question and it is the same situation, you will not be required to submit the same documentation. Please indicate on your application that the same documentation was previously submitted and the department will use the documentation from your registration file.

5. **Education**

   An official transcript must be provided as evidence of fulfillment of the coursework required. Request a transcript to be mailed directly from the school to the Department of Health.

6. **Course Topics Identification**

   This section should show completion of ninety quarter or sixty semester college credits in courses from an approved school. At least forty-five quarter or thirty semester credits must be in courses relating to the chemical dependency profession and shall include the topics listed in WAC 246-811-030(2), (a) through (w). Please list the course topic you took and the course number associated with it. One course may be used for more than one topic area.

7. **AIDS Education And Training Attestation**

   Please carefully read the AIDS education and training attestation on page 4 of the application. After you have completed a minimum of 4 hours of AIDS education, sign and date this attestation. It is your responsibility to maintain records documenting the education for 2 years and be prepared to submit those records to the department if requested. You are considered to have met the requirements of this section if you have taken and passed the course, HIV/AIDS Brief Risk Intervention for the Chemically Dependent, as described in WAC 246-811-030 (2)(g).

8. **Applicant’s Attestation**

   After you have familiarized yourself with the statutes cited in your law book, please sign and date the attestation.

Washington State Department of Health

Chemical Dependency Professional Certification Application Deadlines And Exam Information

90 Days Prior to the Exam

Your complete application form and application fee for certification must be postmarked no later than 90 days prior to the exam dates listed below. There are no exceptions to the application form and application fee deadlines.
Please be aware that the **application fee is non-refundable**.

60 Days Prior to the Exam

Verification forms, transcripts, and any other supporting documentation required to complete your application file, including any special accommodation requests, are considered supporting documents and must be postmarked 60 days prior to the exam date.

The Application Process

When a complete application form and application fee are received in this office, a candidate file is created. Supporting documents are matched to the candidate file as they arrive. If more documentation is required to complete the file, a letter will be sent to the candidate requesting the additional information. Once the candidate file has met the requirements it will be approved for examination. A letter confirming the examination approval will be sent. An examination registration form will also be sent with the approval letter. *A candidate will not be allowed to register for the examination until the candidate file has met all the State requirements and the examination approval letter has been received.*

Mail All Fees To:

Chemical Dependency Professional Program
PO Box 1099
Olympia, WA 98507-1099

Mail Supporting Documents To:

Chemical Dependency Professional Program
PO Box 47869
Olympia, WA 98504-7869

The National Exams:

National Certification Examination for Addiction Counselors

Level 1 or Level II

An Overview

Passing either exam qualifies a candidate for

Washington State Certification as a Chemical Dependency Professional.

Content Of The Examination:

The certification examinations for Addiction Counselors are written examinations each composed of a maximum of 250 multiple-choice, objective questions with a total testing time of four (4) hours. The content for the examination is described in the Content Outline starting on page 4 of the State Candidate Information Leaflet that you will receive with your examination approval letter.

Within six to eight weeks after taking the examination, candidates will receive a notification letter from the Department of Health regarding their state certification status.

Deadlines

Application Fee & Form	Supporting Documents	Exam Date
August 20, 2004	September 20, 2004	November 20, 2004
December 19, 2004	January 19, 2005	March 19, 2005
April 30, 2005	May 30, 2005	July 30, 2005
August 29, 2005	September 30, 2005	November 19, 2005

Washington State Department of Health
Health Professions Quality Assurance
Chemical Dependency Professionals
P.O. Box 1099
Olympia, WA 98507-1099

For Office Use Only	
CERTIFICATION NO:	CERT. DATE:
APPROVED BY:	
VALIDATION INFORMATION:	

CERTIFICATION #

Application For Chemical Dependency Professional

Please Type or Print Clearly—Follow carefully all instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

1. Demographic Information

APPLICANT'S NAME | LAST | FIRST | MIDDLE INITIAL

MAILING ADDRESS

CITY	STATE	ZIP	COUNTY

NOTE: Your certification document will show this address and all correspondence from the Department will be sent to this address until you notify us of a change.

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS.)	SOCIAL SECURITY NUMBER **(Required** for license under 42 USC 666 and Chapter 26.23 RCW) — —

GENDER: ☐ Male ☐ Female	BIRTHDATE (MONTH/DAY/YEAR)	PLACE OF BIRTH (CITY/STATE)

Have you ever been known under any other name? ☐ Yes ☐ No

If yes, other name(s):

2. Previous Certification/Licensure/Registration

List all states (including Washington) where certifications/licenses/registrations are or were held.
Specifically list certifications/licenses/registrations granted by examination, endorsement, or grandparenting.

STATE	CERTIFICATION/LICENSE TYPE	LICENSE/REGISTRATION/CERTIFICATION		METHOD OF LICENSURE		
		YEAR ISSUED	NUMBER	EXAM	END	GP

An "Out of State Verification for Registration/Certification/Licensure" form is enclosed and must be sent to each state listed above. Enter your full name and birthdate at the top of the form so the state may identify you. Also contact each state board listed for any fees they might charge you for processing the verification form.

3. Examination Data

Have you taken and passed the:

NAADAC ☐ Yes ☐ No Year? _____

ICRC ☐ Yes ☐ No Year? _____

Are you **nationally** certified by **NAADAC**? ☐ Yes ☐ No

Are you **internationally** certified by **ICRC**? ☐ Yes ☐ No

If yes, verification must be sent directly to the Department of Health, Chemical Dependency Professionals Certification Section, from NAADAC or ICRC, or the state in which you took and passed the examination.

4. Personal Data Questions

YES NO

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

   1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

   1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

   (If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

   Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:

   a. the use or distribution of controlled substances or legend drugs? ☐ ☐

   b. a charge of a sex offense? ☐ ☐

   c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving) ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceedings to have:

   a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself? ☐ ☐

   b. committed any act involving moral turpitude, dishonesty or corruption? ☐ ☐

   c. violated any state or federal law or rule regulating the practice of a health care professional? ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements. ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority? ☐ ☐

9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession? ☐ ☐

5. Education

Please provide a chronological listing of approved school(s) attended. An official transcript is to be requested from the approved school(s) and sent directly from the approved school(s) to the Department of Health, Chemical Dependency Professional Certification Program per instructions.

COLLEGE OR UNIVERSITY	DEGREE AND MAJOR	DEGREE GRANTED	
		MONTH	YEAR

6. Course Topics Identification

Minimum Requirements: WAC 246-811-030(1) and (2), an associates degree in human services or related field from an approved school; or successful completion of ninety quarter or sixty semester college credits in courses from an approved school. At least forty-five quarter or thirty semester credits must be in courses relating to the chemical dependency profession and shall include the topics listed in (a) through (w). Identify the course you took and the course number associated with it. One course may be used for more than one topic area.

TOPIC AREA	COURSE TITLE	COURSE #	DATE
a) Understanding addiction			
b) Pharmacological actions of alcohol and other drugs			
c) Substance abuse and addiction treatment methods			
d) Understanding addiction placement, continuing care, and discharge criteria, including ASAM criteria			
e) Cultural diversity including people with disabilities and its implication for treatment			
f) Chemical dependency clinical evaluation (screening and referral to include comorbidity)			
g) HIV/AIDS brief risk intervention for the chemically dependent			
h) Chemical dependency treatment planning			
i) Referral and use of community resources			
j) Service coordination (implementing the treatment plan, consulting, continuing assessment and treatment planning)			
k) Individual counseling			
l) Group counseling			
m) Chemical dependency counseling for families, couples, and significant others			
n) Client, family and community education			
o) Developmental psychology			
p) Psychopathology/abnormal psychology			
q) Documentation, to include, screening, intake, assessment, treatment plan, clinical reports, clinical progress notes, discharge summaries, and other client related data			
r) Chemical dependency confidentiality			
s) Professional and ethical responsibilities			
t) Relapse prevention			
u) Adolescent chemical dependency assessment and treatment			
v) Chemical dependency case management			
w) Chemical dependency rules and regulations			

7. AIDS Education and Training Attestation

I certify I have completed the minimum of 4 hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and the psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my certification may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS	DATE

8. Applicant's Attestation

I, _____ , certify that I am the person described and
NAME OF APPLICANT

identified in this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my certification to practice in the State of Washington.

_____ _____
SIGNATURE OF APPLICANT DATE

Official Use Only

Washington State Records Center

Washington State Department of Health

Out Of State Verification Of Registration/Certification/Licensure As A Chemical Dependency Professional

APPLICANT'S NAME	DATE OF BIRTH (MO/DAY/YR)

I, _____ , Secretary of _____ hereby
OFFICIAL NAME OF BOARD

certify that _____ was granted State Registration/Certification/Licensure
APPLICANT'S NAME

Number _____ to practice _____ in the

State of _____ on the _____ day of _____ , 20 ___ on the basis of:

☐ Successfully passing the required examination

☐ Grandparenting

Did the applicant take and pass the **NAADAC exam**? ☐ Yes ☐ No Score _____

Did the applicant take and pass the **ICRC level II or higher exam**? ☐ Yes ☐ No Score _____

Required Education? _____

Required Experience? _____

Status of credential: ☐ Current Expiration Date _____

☐ Expired Date _____

Legal/Disciplinary Action: ☐ Yes ☐ No

If yes, explain and provide any applicable documentation: _____

I further certify that the preliminary and professional education of this applicant was verified by this Board prior to the examination of the applicant.

Acting on behalf of the _____ _____
SECRETARY DATE

_____ _____
OFFICIAL NAME OF BOARD TELEPHONE

State Seal

Return to: Chemical Dependency Professionals Program
PO Box 47869
Olympia, WA 98504-7869

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Washington State Department of Health

Verification Of Supervised
Chemical Dependency Professional Experience

Note: Use one form per supervisor for each time frame worked.

Print or type clearly

Applicant

APPLICANT'S NAME LAST	FIRST	MIDDLE	DATE OF BIRTH(MO/DAY/YR)

STREET ADDRESS		
CITY	STATE	ZIP
HOME TELEPHONE ( )	BUSINESS TELEPHONE ( )	

Direct Supervisor

The above applicant requires verification of supervised experience for certification as a chemical dependency professional. Please complete the following.

SUPERVISOR'S NAME LAST	FIRST	MIDDLE	DATE OF BIRTH (MO/DA/YR)

STREET ADDRESS		
CITY	STATE	ZIP

Supervised Experience (WAC 246-811-045):	From	MONTH	DAY	YEAR	To	MONTH	DAY	YEAR

Proficiencies acquired during the experience (WAC 246-811-047). The first fifty hours of any face-to-face client contact must be under the direct observation of an approved supervisor or chemical dependency professional.

I attest that the first fifty hours of face-to-face client contact was under my direct observation or I assigned a chemical dependency professional to have direct observation in my stead.

SIGNATURE OF SUPERVISOR _____ DATE _____

Topic	Number of Hours
Face-to-face clinical evaluation **100 hours required**	
Other clinical evaluation **100 hours required**	
Face-to-face counseling to include: Individual counseling, group counseling, and counseling family, couples, and significant others **600 hours required**	
Discussions of professional and ethical responsibilities **50 hours required**	
Transdisciplinary foundations: Understanding addiction treatment knowledge, application to practice, professional readiness, referral, service coordination, client, family, and community education, documentation to include, screening, intake assessment, treatment plan, clinical reports, clinical progress notes, discharge summaries, and other client related data. **AA degree = 1,650 hours required** **BA degree = 1,150 hours required** **MA degree = 650 hours required**	
Total Number of Supervised Experience Hours	

(OVER)

Statement Of Qualifications

Note to Supervisor: To be considered an **appropriate supervisor,** your qualifications must either meet or exceed the requirements of a certified chemical dependency professional in the state of Washington, and who would be eligible to take the examination required for certification. You must have at least four thousand hours of experience in a state approved chemical dependency treatment agency. The four thousand hours are in addition to the supervised experience hours required to be eligible to become a chemical dependency professional. Twenty-eight clock hours of recognized supervised training may be substituted for one thousand hours of experience. You are not a blood or legal relative, significant other, cohabitant of the supervisee, or someone who has acted as the person supervised's primary counselor.

Do not sign this form verifying applicant's hours unless you meet the criteria and can provide documentation if called upon to do so.

My qualifications include:

I certify that the above information is, to the best of my knowledge, accurate and complete. I understand that the Department may request additional information, if it is needed, to evaluate the application of the individual named on this document. I also attest that I meet or exceed the educational and supervision requirements for certification (as required by WAC 246-811-049).

SIGNATURE OF SUPERVISOR

DATE

Return to: Chemical Dependency Professionals Program
PO Box 47869
Olympia, WA 98504-7869